# Introduction to Integrated Behavioral Health Services

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# Disclosures

- Employed by St. Peter's Medical Group
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- Member/Representative of Montana Psychological Association

# Roadmap to Integration

- Brief history of Behavioral Health Integration in Primary Care
- Definitions of behavioral health integration
- Overview of St. Peter's Medical Group Integration Project
- The Role of Behavioral Health in Three Parts
  - Clinical
    - Achieving the Triple Aim
      - Experience of care, population health, cost
  - Operational
    - Creation of common language, processes, and measures of levels of integration
    - Documentation
    - Improving primary care productivity and satisfaction
  - Financial
    - Revenue/billing/reimbursement

# Integrated Behavioral Health: A Brief History

- First integrated behavioral health program
  - Gouverneur Health Program, New York, 1970s
- Turning point in 1995
  - Published evidence for effectiveness (Katon et al, 1995)[1]
  - Formation of physician/behavioral health organization (Collaborative Family Health Association)
- Exponential growth starting in early 2000's
  - IMPACT studies
  - PCMH model
  - HRSA
  - DoD/VA
  - AHRQ
  - SAMHSA

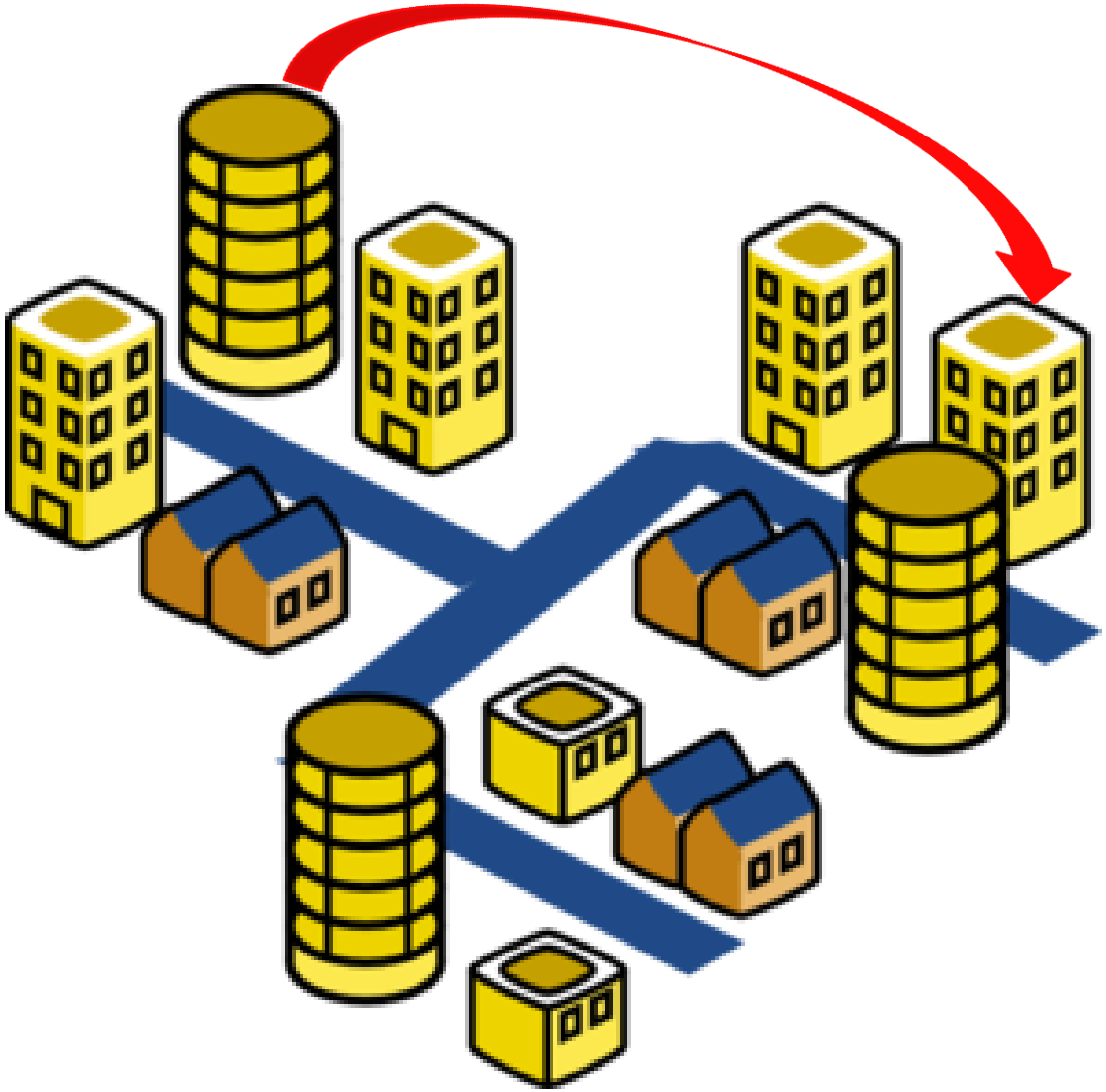
1. Katon et al., 1995

# Some Definitions

Integrated Behavioral Health

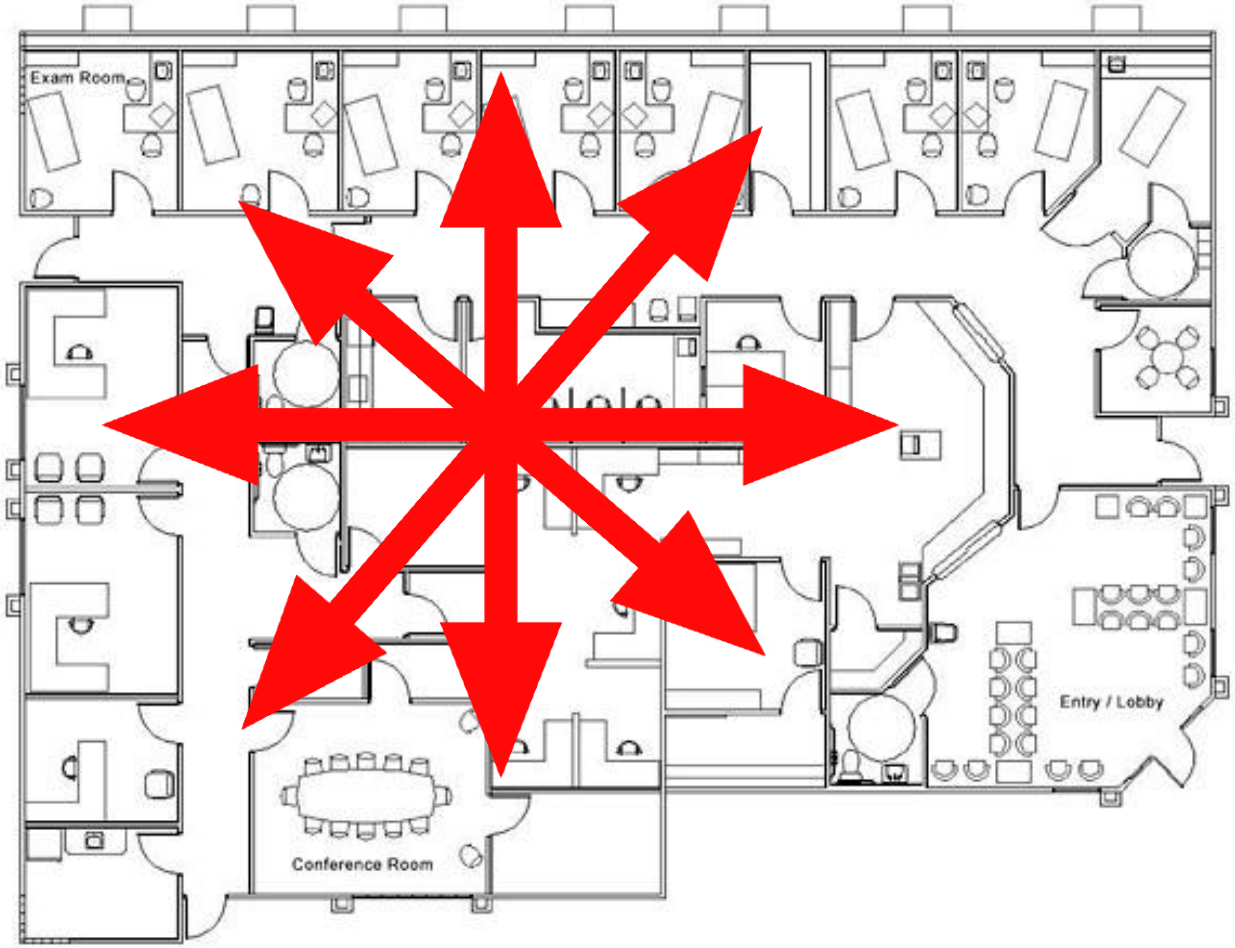
- Behavioral Health Consultant (BHC)
  - Behavioral health specialist (clinical psychologist, other mental health provider) that provides integrated services
- Behavioral health services in a primary care setting
  - Behavior modification/disease management: smoking cessation, med adherence, diet, exercise
  - Mental health: depression, anxiety, etc.
  - Prevention: establishing healthy habits, detection of subclinical symptoms
- Based on a primary care model and pace of clinic
- Population-based health focus
- Consultative role within a primary care treatment team
- Different levels of integration
  - Coordinated, co-located, integrated
  - Targeted or non-targeted populations

# Coordinated



# Co-Location

# Integration



# What Integrated Care Looks Like

- Consultation versus psychotherapy
  - Teach, coach, advise
  - Brief: 5-40 minutes
- PCP remains in charge of patient
  - Referral to more intensive community resources if necessary
  - Consult with primary care team to focus on relevant goals/interventions
- Work looks like primary care
  - Brief, episodic
- Focus on population versus individual case
  - Outcomes of the group
  - Distribution of outcomes within the group
- Interventions target: patient, population, system, and/or community

# Some Differences

| | Behavioral Health Consultant | Specialty Mental Health |
|---|---|---|
| Primary Consumer | Primary Care Provider | Patient/Client |
| Care Context | Team-based | Autonomous |
| Accessibility | On demand | Scheduled, wait list |
| Ownership of Care | PCP | Therapist |
| Productivity | High | Low |
| Care Intensity | Low | High |
| Problem Scope | Wide | Narrow/Specialized |
| Termination of Care | Moving toward goals | Met goals |

# The Need


Percent of the time the 14 most common physical complaints have no identifiable organic etiology[2]


Percent of people with a behavioral health disorder that visit primary care at least once each year[3]


Percent of all behavioral health disorders are treated in primary care[4]

2. Kroenke & Mangelsdorf, 1989
3. Narrow et al., 1993
4. Kessler et al., 2006

# The Problem


Percent of people with behavioral health disorders that do not get behavioral health treatment[5]


Percent of referrals from primary care to outpatient mental health that do not make first appointment[6,7]


PCPs that reported not being able to access outpatient behavioral health services for their patients[8]

5. Kessler et al., 2005
6. Fisher & Ransom,1997
7. Hoge et al., 2006
8. Cunningham, 2009

# Emerging Roles for Behavioral Health in Primary Care

| Direct Patient Care | Patient Screening | Patient programs | Clinical consultation | Practice organization |
|---|---|---|---|---|
| Traditional visits | MH screening | High utilizers | Clinicians | Coaching |
| Diagnostic visits | Self-management | Co-morbid conditions | Case managers | Improvement Programs |
| Handoffs | Symptom monitoring | At-risk/vulnerable | Other staff | Patient flow |
| Intervention | Data collection | Group programs | Administration | Staff training |
| Family engagement | Health behavior change | Low engagement | Human Resources | Self-care/wellness |

# Where Integration is Happening

- Geisinger Health Systems
- Cherokee Health Systems Tennessee
- Intermountain Health System, Utah
- DoD
- VA
- FQHCs
- Family Medicine Residencies
- St. Peter's Medical Group
- St. Luke's System in Idaho
- Frances Mahon Deaconess Glasgow, MT
- Riverstone Health, Billings, MT
- Mid-Columbia Medical Center, The Dalles, OR
- Center for Family Development, Eugene, OR

# Recognition Outside Mental Health

- NCQA 2014 PCMH Standards Priorities
  - Further integrate behavioral health
  - First of six priorities of revision
- Addendum to 2007 Joint Principles of the Patient Centered Medical Home[9]
  - Integrating behavioral health care into the PCMH
    - Endorsed by 11 family medicine and primary care organizations
    - Emphasizes centrality of behavioral healthcare as part of the PCMH
- Mental Health Parity and Addiction Equity Act 2008
  - Financial requirements and treatment limitations for MH/SUD are no more restrictive than med/surg
- Affordable Care Act 2010
  - Marketplace plans required to have MH/SUD coverage
  - Covers preventative services and screenings

9. Annals of Family Medicine, 2014

# SPMG/PacificSource Project

- Embed a behavioral health consultant in the primary care setting to target specific but common ambulatory sensitive conditions
  - First line recommendations are lifestyle changes (diabetes, hypertension, tobacco use, depression, etc.)
  - Specified evidence based interventions
- Six PCPs were designated to roll out program
  - Two at a time to allow workflow and process adaptations
- Education
  - Nurse and provider meetings
- Building care team resiliency
  - Satisfaction surveys
  - Feedback and resiliency training offered

# Clinical

# Goals of Integrated Behavioral Care

- The Triple Aim:
  - Enhancing patient experience of care
  - Improving population health
  - Improving the per capita cost of care
- "A team with a shared population and mission, using a clinical system supported by an office practice and financial system and continuous quality improvement and effectiveness measurement."[10]
- Create a patient-centered care experience and achieve a broad range of outcomes- clinical, functional, quality of life, and financial – for each patient that no one provider and patient are likely to achieve on their own. [10]

10. Peek, 2011.

# The Triple Aim: Patient Experience

- Patients reported more satisfaction compared to specialty mental health referral[11]
- 50% better access to mental health care if offered in primary care [12]
- Reiter & Manson, 2014
  - 76% of patients satisfied with ability to get appointment
  - 86% felt BHC understood their problem
  - 89% said it was helpful to meet with BHC
  - 65% said physical health improved
  - 72% said mental health improved
- Enhance sensitivity to patient beliefs and preferences through a biopsychosocial approach[13]

11. Chen et al., 2006
12. Bartels et al., 2004
13. Kwan & Nease, 2013

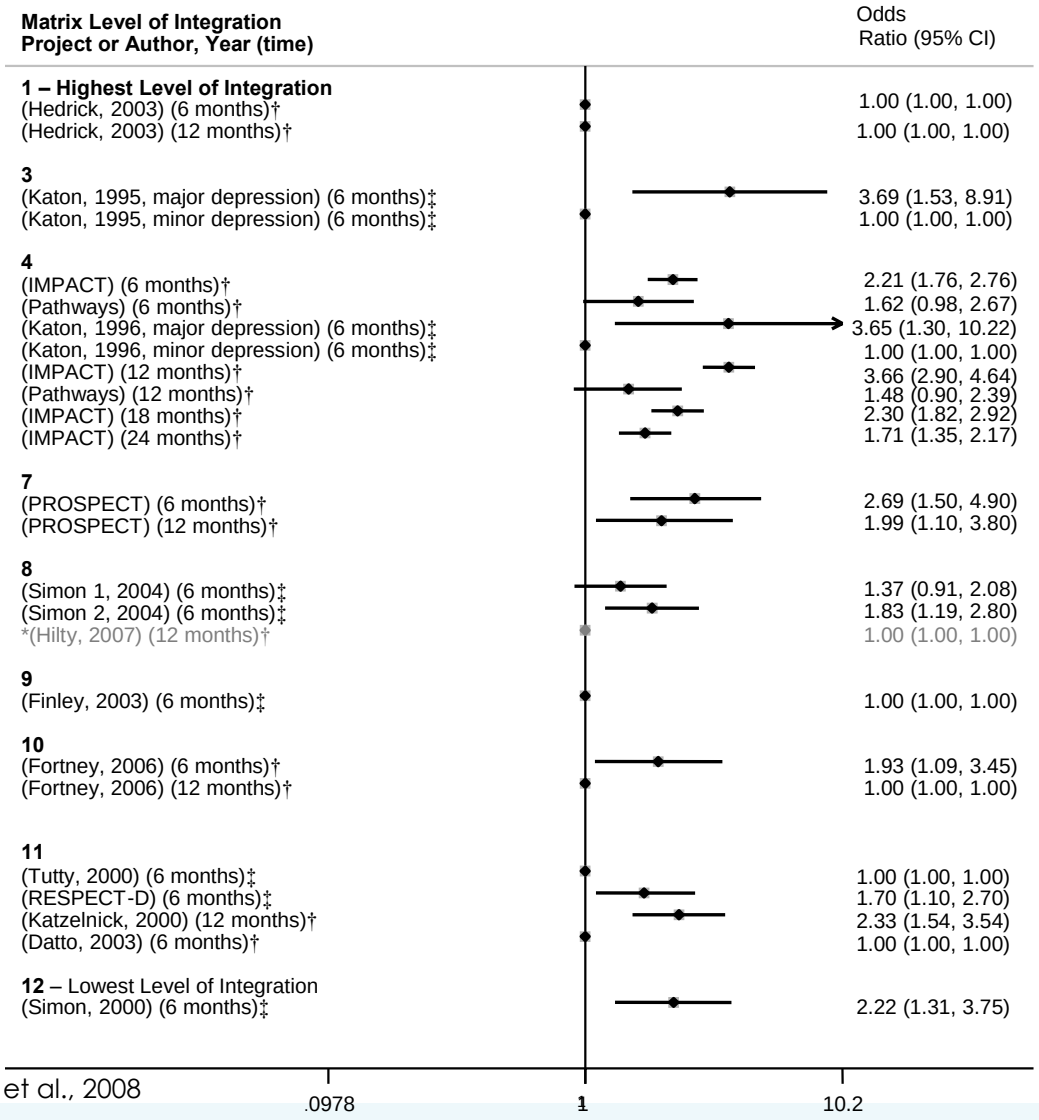
# The Triple Aim: Outcomes

- Outcomes for depression were significantly improved at 6 months and 5 years with collaborative/integrated care[14]
- Risk of cardiac event reduced by 45% with cognitive behavioral interventions[15]
- Cognitive behavioral interventions in addition to treatment as usual resulted in 5.4 fewer absentee days than treatment as usual in 6 months following intervention[16]
- An intervention for overweight/obese patients that included behavior modification, diet, and exercise was the most effective and least costly per QALY gained compared to other intervention combinations[17]

14. Gilbody et al., 2006
15. Gullikkson et al., 2011
16. Schweikert & Jacobi, 2006
17. Roux & Kuntz, 2006

# The Triple Aim: Outcomes

**Figure 11. Treatment response by matrix level of integration**




18. Butler et al., 2008

# Improved outcomes and cost savings[19,20,21]

- Depression, anxiety
- Diabetes
- Tobacco use
- Insomnia
- Headache
- Chronic Pain
- COPD
- Substance use
- Obesity, exercise, diet
- Cancer
- Cardiovascular disease and associated factors
- High utilization
- Somatization
- Abuse, neglect, adverse childhood experience
- Gastrointestinal disorders

19. Blount & Miller, 2009
20. Kessler & Stafford, 2008
21. Strosahl & Robinson, 2008

# The Triple Aim: Costs

- IMPACT depression care resulted in mean $3,500 lower healthcare costs per patient per year compared to treatment as usual[22]
- Lifestyle interventions to prevent diabetes in patients with impaired glucose tolerance is cost effective at $3,300/QALY[23]
- Hospital readmissions fell 2% for patients in integrated primary care compared to 5% increased admissions for controls[24]
- For CAD patients Stress management education was superior to assigned exercise for reduced CAD events at 1, 2 and 5 years, and lower cumulative medical costs at 5 years[25]
- Cost of care for patients with diabetes and moderate to severe depression were 86% higher than low severity patients[26]

22. Unutzer et al., 2008
23. Lindgren et al., 2007
24. Sommers et al., 2000
25. Blumenthal et al., 2002
26. Ciechanowski, Katon, & Russo, 2000

# Summary

- Improve early detection (via screening) of mental health and behavioral problems, before they become more severe and more costly
- Treat mental health problems presenting as medical issues, which leads to overutilization of health care services
- Provide mental health services where patients are seeking them (primary care), at the time they are seeking them
- Treat mental health problems that exacerbate medical conditions (e.g., depression and CVD, panic disorder and COPD), lengthen hospital stays, delay recovery from surgery, interfere with treatment adherence, etc.
- Address health-related behaviors (medication adherence, diet and exercise, smoking) that significantly impact physical health and contribute to most of the leading causes of death in the US (e.g., heart disease, cancer, stroke, diabetes, etc.)
- All of the above enhance patient experience of care, improve population health, and lower the cost of care

# Operational

# Operational aspects of integration

The Lexicon for Behavioral Health and Primary Care Integration[27]

- Creating common language, processes, and measures
- Developed by expert consensus
  - clinicians, care systems, health plans, payers, researchers, policymakers, business modelers, and patients
- Creates a framework while maintaining adaptability
  - Workflows
  - Referral pathways
  - Care team roles
  - Organizational structure
  - Scheduling/access
  - documentation

27. Peek, 2013

# Provider and Care Team

- Primary care burnout ranges from 26-65%[28,29]
  - Symptoms: emotional/physical exhaustion, depersonalization, decreased experience of accomplishment
  - Signs: re-specialization training, early retirement, substance use, physician shortage, absenteeism, presenteeism
- Patients build rapport better with low-burnout providers[28]
- Administrative support and positive team relations resulted in twice as many patient reports of high satisfaction and significantly lower burnout among care team members[29]

28. Ratanawongsa, et al., 2008
29. Vahey,et al.,2004

# Enhancing Care Team Interaction and Satisfaction

Reiter & Monson 2014 survey of providers

- All PCPs reported
  - Satisfaction with the BHC service
  - Improved job satisfaction
  - Better able to address behavioral problems
  - Recommend the service for other sites
- A majority (> 80%) said because of BHC
  - More likely to continue with employer
  - Able to see more patients in 20 minutes
  - Recognize behavioral issues better

Other ways BHCs can enhance care team

- Including patients as part of the team
  - Passive v. active
- Relationship and communication strategies
  - Goal and agenda setting
  - Listening styles
- Provider Motivational Interviewing/Enhancement
  - Goal-oriented, guiding communication
  - Explore and resolve ambivalence
- Acceptance and Commitment Training
  - Open to experience
  - Aware of present moment
  - Engaged in value consistent action

# Why engage in patient centered interactions?

- It results in improved health outcomes[30]
- 10 times greater patient satisfaction[30]
- 5 times more likely to report high QoL scores[30]
- When patients set their own goals, they report higher physical and mental functioning scores[30,31]
- When patients are engaged and activated they:
  - Engage in preventative and health behaviors[32]
  - 27-42% more likely to adhere to medication regimens[32]
  - 50% less likely to have a 30 day hospital readmittance[32]
- Patients who get more support for self-management from healthcare providers are more likely to be engaged and activated[33]

30. Mosen,et al., 2007
31. Cleland & Ekman, 2010
32. Hibbard, 2008
33. Center for Studying Health System Change 2007

# Financial

# The Role of Behavior in Health

"To achieve true patient centeredness… we can't afford to ignore …more than half of what [determines health]. The answer is not to focus on the 10% we most easily control when a patient is sick"[34]

- 10-15% of preventable mortality in the US could be avoided by better medical care[35]
- 40% of premature mortality is determined by patients' behavior[34,35]
- 15% determined by societal circumstances[34,35]
  - Behavioral choices account for at least 900,000 deaths annually—all of the early deaths by definition[35]
  - Top 3 causes of death in the US in 2000
    - Tobacco use, Poor diet, Physical inactivity[36]
- Behavior is thus the single greatest influence on population health[35]

# Reimbursement Discussion

- Separate funding streams
  - Carve-ins, carve-outs
  - Prevent integration of medical and behavioral services
- Same day billing
  - Necessary for effective service delivery
- Types of billing
  - Traditional psychotherapy codes
    - Require a mental health diagnosis
      - 90832, 90834, 90837
  - Health and behavior codes
    - Billed under medical diagnosis for psychosocial intervention
      - 96150-96155
  - Telephone/email services
    - 98966-98969
  - Other services
    - Screening, care management, coordination, collaboration, telehealth

# Separate streams[36]

- 90% of patients with mental health/substance use disorders seen in general medical sector
- 66% of patients with MH/SUD in general medicine receive no treatment
  - Of the 33% that do, only 10% receive evidence-based interventions
- MH/SUD resources, with psychotropic exception, is focused on 10% of patients seen in specialty mental health sector
  - Focus is on number of interventions/year, not outcomes

36.1. Kathol, Melek, Bair, & Sargent, 2008

# Recommendations

- Payment for behavioral health specialists would be a part of the PCMH total health budget [9,36,37,38,39,40]
  - Segregated BH and medical payments most common factor that prevents integrated program initiation, development, and sustainability[37]
  - HRSA, AAFP, IoM have all recommended behavioral health specialists be included on the primary care service team
  - During transition, use of other codes are necessary
    - H&B, E&M[41]
- Same day services are necessary [9,36,39]
- Behavioral work involves face-to-face, as well as telephone, electronic communication, and remote monitoring[9,39]
- Behavioral work also involves communication and coordination with other team members, families, caregivers, and school personnel[9,39]

9. Annals of Family Medicine, 2014
36. Kathol, Melek, Bair, & Sargent, 2008
37. Manderscheid & Kathol, 2014
38. Kathol & Rollman, 2014
39. Fisher & Dickinson, 2014
40. Blount et al., 2007
41. Kessler, 2008

# Recommendations

- Include behavioral health specialists in cost savings that are associated with coordinated care, improved physical and behavioral health, and lower patient costs[9,36,37]
- Mental health, substance abuse screening and intervention as well as targeted screening for high-need, high-cost populations[9,38,39,40]
- Measure outcomes for: Clinical, Functional, Quality of life, Satisfaction goals[9,38,39,40]
- Care management to coordinate across inpatient, outpatient, and community medical-behavioral continuum[9,38,39,40]

9. Annals of Family Medicine, 2014
36. Kathol, Melek, Bair, & Sargent, 2008
37. Manderscheid & Kathol, 2014
38. Kathol & Rollman, 2014
39. Fisher & Dickinson, 2014
40. Blount et al., 2007
41. Kessler, 2008

# Summary Goals

- Educate
  - Behavioral health integration is more than just dropping any mental health professional into a primary care setting
    - Specific KSAs are needed to succeed in medical settings
  - Behavioral health integration works clinically, operationally, and financially to achieve the Triple Aim
    - Primary Care is the de facto mental health system
    - And addressing certain aspects will ensure patients have access and benefit from these services
- Move the conversation
  - From "Is behavioral health integration an effective component of the PCMH?"
  - To "Because behavioral health integration is effective component of the PCMH, how do we ensure it is part of Montana's strategy?"
  - From the immediate costs
  - To the immediate and enduring patient outcomes
- Recommendations
  - There is a great deal of flexibility implementing clinical and operational aspects based on specific needs and the best evidence
  - Specific payment reforms are necessary

# Questions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